DEPARTMENT OF HUMAN SERVICES
FATALITY REVIEW ANNUAL REPORT

JULY 1, 2008 – JUNE 30, 2009

EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within the 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2009, 129 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were seven suicide deaths (5%) and six homicides (4.7%). The reviews indicate that abuse and/or neglect were contributing factors in seven (5%) of the 129 deaths. Six children, 11.5% of fatalities reported by the Division of Child and Family Services (DCFS) and 5% of the total DHS fatalities, died as the direct result of abuse or neglect by their parents/caretakers.

Of the 52 fatalities reported by DCFS, 51 reviews were held (98%) with one review pending. Forty-nine of the 50 reported DSPD fatalities were reviewed (98%) with one review pending. Seven Division of Juvenile Justice Services (DJJS) fatalities were reviewed (100%). An on-site review was held for one (14%) of the seven reported Utah State Developmental Center (USDC) fatalities with six reviews (86%) pending. Formal death reviews will be held at USDC when officials have received all medical records and other pertinent information concerning the deaths. Utah State Hospital (USH) conducted on-site reviews for its four reported fatalities (100%). Two reported deaths (100%) from the Division of Aging and Adult Services (DAAS) were reviewed. The Office of the Public Guardian (OPG) reported the deaths of seven individuals for whom they provided services. One of these individuals (14%) was also receiving services through USDC at the time of her death. OPG provided comprehensive written reports detailing services provided to their seven clients (100%).

There were 71 (55%) reported deaths of male clients and 58 (45%) reported deaths of female clients. Reported deaths included 31 infants (24%) under the age of one year; 31 (24%) clients between the ages of one to 18 years; 29 (22.5%) clients between the ages of 19 to 50 years; and 38 (29.5%) clients between the ages of 51 to 90 years.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

During FY 2009, the fatality review committees consisted of a board member of the division under review, the Attorney General or designee for the division, a member of management staff (supervisory level or above) from the designated division and from a region other than that in which the fatality occurred, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee. DHS Fatality Review Policy indicates that the committee may also include individuals whose expertise or knowledge could significantly contribute to the review process, a member of law enforcement, a member of the Child Welfare Legislative Oversight Committee, and/or a physician, medical practitioner, or registered nurse. The Child Fatality Review Committee has been strengthened by the participation of a pediatrician who was also a member of the DCFS Board, a representative from the Division of Substance Abuse and Mental Health, and by the Director of the DCFS Professional and Community Development Team. The Director of Professional and Community Development provides a vital link between the committee and DCFS as she and her team develop or strengthen training to address identified problematic patterns of practice.

The DSPD Fatality Review Committee has utilized the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. The RNs' medical knowledge and insight into health and safety issues is of great value to non-medical committee members.

Notification of client deaths is received through Deceased Client Reports, Certificates of Death, the Office of the State Medical Examiner, newspaper obituaries, emails, etc. The Department of Health provides the Fatality Review Coordinator with Certificates of Death for every child in the State of Utah who dies between the ages of birth and 21 years. These certificates are checked against the child welfare database, SAFE, to determine if the child or his family has had services within twelve months of the death. If services were provided within this time period, the Coordinator requests and reviews the family's DCFS case file, makes a written summary of the family's history of involvement with the Division and makes analyzes pertaining to case practice and agency culpability.

Prior to the monthly DSPD and Child Fatality Review committee meetings, members receive copies of fatality review reports to study and to note areas for discussion. When deemed appropriate, the Committees invite Division staff and/or contract providers to committee meetings to provide additional information. Following the committee review, the fatality review reports, complete with committee concerns and/or recommendations, are sent to the DHS Executive Director, the Director of the division under review, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, a plan of action for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, the JJS Committee meets on an as-needed basis.

In FY 2009 the Child Fatality Review Committee continued the process of waiving the formal committee review process for cases in which there are no practice concerns or in which there is no indication that Division practices contributed to the death of the child. The written summary of services for waived cases follows the same format as that for reviewed cases with the addition of the Coordinator's recommendation that the formal review process be waived.

The full report is then reviewed by the Child Fatality Review Committee Chair, currently the Director of the Office of the Guardian ad Litem, and by the Director of the Office of Services Review. If the Chair and Director concur with the Coordinator's recommendation to waive the formal review, they sign off on the recommendation. Child Fatality Review Committee members are provided with the Findings and with the Systemic Analyses of waived cases. Committee members can request a full review of any case for which the formal committee review has been waived.

Fatality Review reports are classified as Private/Protected. The content of the fatality report, i.e., the summary of services to the individual and/or his/her family is classified as "Private". The Fatality Review Committee's analyses of concerns regarding practice and the Committee's recommendations to the Division are classified as "Protected". Requests for copies of fatality reports must meet GRAMA criteria for these classifications. An Executive Summary that meets GRAMA specifications is available for public release.

The DHS Fatality Review Coordinator represents DHS as a member of the Multidisciplinary Child Fatality Review Committee (MCFRC), which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The MCFRC is a collaborative process that includes professionals from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

The MCFRC meets with the Utah State Medical Examiners on an as-needed basis to review the deaths of children whose deaths occur under violent, suspicious, unattended, or unknown circumstances and to review the deaths of children who have committed suicide. Committee members pool information regarding prior services to and/or involvement with the decedent/decedent's family, identify causes of preventable deaths, make Child Protective Services referrals, make recommendations for follow-up services when appropriate, attempt to identify interventions that could prevent future deaths, and provide information to law enforcement during child homicide investigations.

The MCFRC has been instrumental in creating a Suicide Task Force, in partnering to complete a six-phase Youth Suicide Study, in working toward more comprehensive child-restraint and seat belt legislation, and in developing news releases, public service announcements, and media events to address the most common injuries among Utah's children.

FINDINGS

The purposes for reviewing a Department of Human Services client death are to assess the Department's culpability in that death, to develop means for preventing future client deaths, and to improve Department services to children and adults. The review itself evaluates the system's response to protecting vulnerable clients. Committee members attempt to assess if "best practice" was followed during the provision of services to individuals and families.

During FY 2009, the DHS Fatality Review Committees received reports of the death of 129 individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in 126 cases (98%), services provided to the clients and/or their families did not contribute to the clients' deaths. There was no direct relationship between clients' deaths and services provided in the 52 DCFS fatalities. In three of the 50 DSPD fatalities (6%) a relationship exists between the clients' deaths and failure on the part of workers, contract providers, or medical providers to follow best practice procedures. Summaries of these cases follow:

- Provider staff was assisting a 59-year-old female to the bathroom with the use of a Gait belt and a walker when the woman began to fall. Although staff had been trained on the correct procedure for easing an individual to the floor if they began to fall, this staff reportedly "panicked" and left the woman alone while she went for the wheelchair**.** While staff was gone, the client's "knees gave out", and she fell, hitting her head on a pipe under the sink. The woman was transported by ambulance to the hospital where x-rays revealed that she had fractured T-5 vertebrae. She was transferred to a Salt Lake City hospital where she was intubated due to breathing difficulties, fitted with a feeding tube due to swallowing difficulties, and administered multiple medications to address her high pain levels. After two weeks of hospitalization the woman received a trach tube, became very weak, and required full assistance when sitting. Two months after her fall and the day after being transferred to a rehabilitation facility, the woman died due to problems with her tracheostomy.

- Provider staff were informed on Sunday that a 79-year-old male, who had been attending church, "did not look good" and that he was "walking slowly". Staff went to the man's home and also noted that he was "walking slowly". Staff made an appointment for the man to be seen by his doctor the following Tuesday. However, on Monday provider staff and home health staff who had been to the man's home noted that although he was ambulatory, the man's chest was "rattling a bit". Evening staff called an ambulance, and the man was transported to the hospital where he was diagnosed with pneumonia. The man's physical condition deteriorated very quickly, and he died early the following morning of cardiac arrest due to pneumonia and hypoxia.

- A 62-year-old male fell at his supported employment site and was unable to get up. Two hours after the injury the day service provider attempted to reach the residential coordinator but did not make contact for two additional hours. The day service provider did not attempt to contact the DSPD Support Coordinator. During the hours after his injury, day and residential staff transferred the injured man in and out of a van several times, onto a chair, and into a wheelchair even though he could not bear weight and was "screaming in pain". The day provider eventually transported the man to his home and "dropped him off". Day program administration accepted no responsibility for the incident or for not obtaining medical treatment and stated that it was the agency's policy to contact the residential provider before the agency did "anything". Agency

administration also reported that they were not sure who had been supervising the client when he fell, as the job coaches "switched during the work shift".

Residential staff took the man to an Instacare where it was determined that he had cracked his hip. During partial hip-replacement surgery, the man's surgeon noted that there were fresh scars in the bone indicating that the man had fallen in the past. However, the surgeon stated that it was the current fall that had caused the hip bone to crack.

Three days following surgery the individual was transferred to a rehabilitation facility, and three days after the transfer, he was readmitted to the hospital with suspected pneumonia. Due to the seriousness of the man's condition, the Emergency Room doctor attempted to intubate him. Because of difficulties during the intubation process, medical staff gave the patient medication to "put him out". Shortly thereafter, the man went into cardiac arrest. After thirty minutes of CPR the man was pronounced dead. A hospital RN reported that one of the man's monitors had come off, which meant that medical staff did not realize the man was in cardiac arrest "as soon as they would have liked". The cause of death was certified as cardiopulmonary arrest due to a possible pulmonary embolus.

Of the 52 reported child fatalities five deaths (9.6%) were attributed to abuse or neglect by a parent or caretaker. The following children died as the result of abuse or neglect:

- The cause of a six-month-old male's death was certified as "Sudden Unexpected Death due to Post-traumatic Seizures as a result of Blunt Force Injuries of the Head". At the age of one month the infant was severely physically abused by his father. He was hospitalized for one month before being court ordered into foster care and before being placed in a foster home designated for medically fragile infants. Multiple medical specialists were treating the baby and following his progress. It was their opinion that the baby would have very pronounced and severe needs throughout his life. While in foster care, the infant experienced seizures and died as the result of the injuries sustained during the physical abuse. The infant's older brother was ordered into State's custody and was placed with his maternal grandparents while his mother completed the requirements of her service plan. The infant's father is facing a charge of aggravated murder.

- A twenty-three-month-old male died as the result of a fatal spinal injury inflicted by his seventeen-year-old mother. The toddler's five-month-old twin brothers, one of whom previously had been hospitalized due to unexplained seizures, were ordered into foster care and were placed in a foster home licensed for medically fragile children. The children's mother and father voluntarily relinquished their parental rights, and the twins were recently adopted by their foster family. The biological mother is incarcerated and has been charged with first-degree felony murder and with two second-degree felony counts of child abuse. The children's father was arrested and charged with second-degree felony obstruction of justice.

- While in the care of his mother's paramour, a four-month-old male sustained fatal injuries and died shortly after being life-flighted to Primary Children's Medical Center. The cause of death is certified as "Inflicted Injuries/Shaken Baby Syndrome". The alleged perpetrator eventually admitted that he had inflicted the injuries out of frustration because the infant and his older brother were crying. The two-year-old brother, who was ordered into foster care, has since been returned to his mother's custody after she

completed all requirements in her DCFS service plan. The alleged perpetrator was arrested and charged with child abuse homicide.

- After initially claiming that her two-year-old daughter had drowned, a mother eventually admitted that she had inflicted the child's fatal injuries and then had attempted to make it appear that the child had drowned by placing her in a wading pool. The cause of death is certified as Blunt Force Injuries to the Torso. The victim's older brother and younger sister are in their father's custody. The mother, who has an extensive history of services through DCFS and who has suffered from mental health issues, is currently incarcerated.

- Seven children, ages eight years to fifteen months, were playing by a fast-flowing river. While the three adult females and two adult males were fishing and "doing other things", a fifteen-month-old female fell into the river and was swept downstream. The toddler had been in the river for approximately twenty minutes before being found, and she could not be revived. Law enforcement is investigating the circumstances of the death, and there is an open CPS investigation into an allegation of non-supervision.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the Health and Safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better assessments of parents' and children's underlying needs, better matching of level of services to level of risk of harm, and better monitoring of contract providers. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

DIVISION OF CHILD AND FAMILY SERVICES

SYSTEMIC STRENGTHS

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continued to improve over casework conducted prior to the advent of the Practice Model. In the majority of cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, aggressively sought appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are conducting Child and Family Team Meetings and are working more closely with clients in an attempt to identify client needs and to plan appropriate services. During the past year, workers have been trained on the Safety Model which places emphasis on assessing a caretaker's capacity to protect. Some examples of good casework include:

- In a case involving the severe physical abuse of an infant the CPS investigator did an excellent job of ensuring the safety and well-being of the victim and his older sibling. She coordinated her investigation with law enforcement, sought and received frequent updates on the baby's medical condition from his doctors and from the hospital social worker, staffed the case with the AAG for removal of the children, and ensured that the sibling was with family members who agreed to protect the child from further harm. Upon the baby's release from the hospital the CPS worker placed him in a foster home designated for medically fragile children with a foster mother who was a Registered Nurse. The Permanency worker referred the children's mother to appropriate service providers and corroborated with service providers that the mother was complying with the terms of her service plan. The Permanency worker monitored the mother's progress and assessed the family's needs through Child and Family Team Meetings and assisted the mother in obtaining Crime Victim Reparation funds to pay for her court-ordered services.

- A child with mental health diagnoses including Mild Mental Retardation and Reactive Attachment Disorder of infancy and early childhood received services through both the Division of Child and Family Services and the Division of Services for People with Disabilities. She was placed in a Professional Parent home with caretakers who were skilled in caring for disabled individuals, and she was provided with extensive wrap-around services including individual therapy, medication management, behavioral management, occupational and speech therapies, and special education services. In addition to the DCFS Permanency worker, the child also had DSPD Support Coordinator case management services. There was excellent cooperation and coordination of services between the two agencies in providing services to the child. After the child's death a Related Parties CPS worker conducted an extremely thorough investigation into the cause of the death.

- The Committee noted commendable work in another CPS investigation. On several occasions the CPS worker spoke with the referent to clarify information pertaining to the allegations, coordinated her investigation with law enforcement, interviewed family members, and kept an out-of-state caseworker fully informed of case progress as it applied to that state's ward who was living in the same foster home as the alleged victim in the CPS investigation. The CPS worker notified the Office of Licensing of the allegations and relayed concerns to that office that surface during the investigation about

the foster parents. The worker staffed the case with the Assistant Attorney General and ensured that her investigative findings supported the disposition.

- Two CPS workers adapted their investigations to the unique circumstances of the child and family that were the subjects of reported abuse. The first worker involved two school district RN's and a DCFS RN in his investigation by taking them to the family home to make an evaluation of the child's medical condition. In a second CPS investigation the worker provided a Mai Mai interpreter for the interview with the child's mother and an American Sign Language interpreter for the child.

- In working with a family that has an extensive history of involvement with DCFS, the CPS, In-home, and Permanency workers sought extensive corroboration of the mother's statements of compliance with service plan requirements. They were firm in confronting the mother about her propensity to triangulate and to lie and expended tremendous effort in attempting to schedule home visits, in maintaining contact with the mother, and in tracking down the family through its numerous changes of residence.

SYSTEMIC WEAKNESSES

In FY 2009 the Child Fatality Review Committee noted some patterns of practice that denote systemic weaknesses among the 52 two reported fatalities. Many of the weaknesses noted by the Committee are inter-related in that deficits in documentation contributed to questions about corroboration of information and follow-through in providing services. Each of these problems could be reduced or eliminated if supervisors were conducting thorough Quality Assurance (QA) reviews on every case. The following issues raised the greatest concern among committee members. It is recommended that during FY 2010, DCFS concentrate on improving case practice in these areas.

Documentation Issues

Deficits in documentation were noted in twelve of the 52 cases (23%). Workers failed to document critical events such as changes in placement, removal information, court hearings and court orders. In at least three cases that had open services at the time of a child's death, the fatality was not noted in the activity logs.

The documentation in the PSS and SCF cases for a family from which multiple children had been removed was lacking in important details. The worker failed to document the reasons for the children's removal and for their entry into State's custody, the outcome of court hearings, information regarding referrals for services, and rationale behind placement decisions. There was also no documentation pertaining to the birth of twins, about the death of one of the babies, or information about the surviving twin.

A CPS worker documented that the Assistant Attorney General (AAG) had approved the filing of a Protective Supervision Services (PSS) petition. However, it is assumed that the petition was never filed, as a PSS case was not opened. There was no documentation explaining the rationale behind the decision not to open the PSS case.

A worker investigating an allegation of non-supervision failed to make any mention in her activity logs of the death of the family's 13-year-old son who was killed during the course of the CPS investigation. The boy was an illegal, un-helmeted passenger on an unlicensed, unregistered motor scooter whose driver failed to heed a stop sign. The circumstances surrounding the fatal accident spoke to a lack of supervision on the part of the decedent's parents.

One week after the closure of a CPS investigation into an allegation of Domestic Violence related child abuse the mother of the family under investigation gave birth to a baby. However, there is no documentation in the activity logs that the mother was pregnant or that her pregnancy was well advanced at the time of the domestic violence incident between her and her husband.

Corroboration of Information and Lack of Follow-through in Providing Services

A systemic weakness identified by the Child Fatality Review Committee during FY 2009 was the failure of some workers to corroborate information given by parents and/or alleged perpetrators regarding their compliance in obtaining and participating in services. Some workers also demonstrated a lack of follow-through in providing services to families. In at least seven of the fifty-two cases reviewed (13%) the Committee noted these deficiencies in case practice.

The CPS investigations pertaining to one family were characterized by a general lack of follow-up or corroboration. Reports from the mother, who appeared to change her account of events depending on the agency to which she was reporting, were not corroborated. Although the mother expressed an interest in working with the DCFS Domestic Violence specialist, there is no documentation that services, other than one home visit, were provided. There appeared to be no follow through with helping the mother obtain mental health treatment or in ensuring that she contacted ORS to apply for child support. There was no corroboration of her report concerning her employment or living arrangements.

In two separate CPS investigations into the same allegation of Fetal Addiction to alcohol or other substance the CPS workers requested that the mother provide them with copies of medical and dental reports related to her drug use and to the medical condition of the baby. It is not documented in either case that the mother complied with DCFS's request, yet the workers closed their cases without obtaining the requested corroborating information.

In a CPS case involving an Asian family with limited English-speaking skills, the worker expended a great deal of time and energy in attempting to locate appropriate services for the children and parents However, at case closure there was no documentation that any of the services were in place. It appears that the worker closed the case before corroborating if the family had registered their child for Head Start or had registered themselves for parenting classes.

The wife/mother in another CPS investigation reported that she and her husband were attending domestic violence counseling. However, the CPS worker did not corroborate that information. The couple's daughter was a witness to a fairly intense incident of domestic violence, yet the worker did not suggest that the parents seek counseling for her nor is it documented that the worker gave the parents information regarding counseling resources for the child.

Following an extremely thorough CPS investigation, a voluntary in-home services case was opened. The PSC worker appears to have invested little effort in working with the family. The three primary areas of concern identified in the Child and Family Assessment are listed as the mother's alcohol and possible drug use; domestic violence between the parents; and the child's need for mental health counseling due to depression stemming from physical and emotional abuse by his father. These concerns were either not addressed in the service plan or appropriate services were not obtained by the parents.

The worker simply asked the parents about their progress in obtaining services and closed the case with their having completed none of the goals and objectives of the service plan.

Supervisory Quality Assurance (QA) Reviews

In at least seven of the fifty-two DCFS cases reviewed in FY 2009 (13%), the Committee noted an apparent lack of supervisory oversight, especially in CPS cases. It appeared that weaknesses noted in CPS and In-home case practice could have been corrected if the workers' supervisors had conducted QA's on each case before closure and had required that the workers correct the CPS protocol and policy omissions and/or gaps in documentation.

While providing CPS and IHS services to a family, a caseworker closed the CPS case having made only one entry in the activity logs relating to contact with the alleged victim. The worker kept the IHS case open for three months during which time she documented no further contact with the victim/family or any additional case activities.

A case of Domestic Violence Services was opened in SAFE for another family, yet there are no activity log entries other than that of the initial case setup. In yet another case there was no documentation in SAFE for two Intensive Family Preservation Services (PFP) cases or for a Counseling Individual Services (CIS) case. All of these services were open during the time when activity logs were kept in the SAFE database. The Child Fatality Review Committee questioned the whereabouts of supervisor oversight in these cases.

DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. If Regions accept the Committee's recommendations, they are asked to submit an action plan outlining how they will implement Committee recommendations.

The DCFS Constituent Services Specialist tracks Child Fatality Review recommendations and ensures that regions are responding to the Committee. At the close of Fiscal Year 2009 the Division had responded to all concerns and recommendations made by the Child Fatality Review Committee. The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the Regions and the Administrative Team have provided to the Committee's concerns and recommendations.

- A CPS investigation on an allegation of Domestic Violence related child abuse raised concerns that the CPS worker might have placed the wife/mother at risk by interviewing her when the alleged perpetrator was in the home; that the worker might not have understood or responded to the dynamics of dealing with an adult domestic violence victim; that the worker did not follow up with the victim or the criminal system; and that the worker did not offer services to the victim. However, additional information was provided during an interview with the CPS worker that showed that she had conducted a more thorough investigation than documentation in the original case indicated. The worker had provided the victim with information on the cycle of violence, had provided service referrals to multiple community support programs, and had determined that the victim had a family support system in place. An additional concern in the case was that the supervisor had not conducted a QA of the case at closure, thus missing an opportunity to mentor the worker in best practice and to ensure consistently good casework. As a result, the region opened a Domestic Violence Services (DVS) case in which it was verified that the perpetrator was on probation and was on a waiting list for domestic

violence counseling and that the victim was working with a DV advocate. An assessment was conducted by the CPS and DV Program Administrators to determine if the CPS worker or the supervisor needed further training.

- A recommendation was made that CPS workers be trained to request medical assessments/consults when signs of abuse are present, especially when the alleged victim is a non-verbal child. The Professional and Community Development Team reported that a specific portion of Core training for new workers is dedicated to instructing them on how to identify signs of abuse and neglect. The Professional and Community Development Team Director indicated that her team would re-evaluate the curriculum for effectiveness.

- Salt Lake Valley Region reported that there is an ongoing effort in that region to address the issue of thorough and clear documentation. Western Region indicated that CPS supervisors have been instructed to train and/or remind CPS staff of the need to document everything used in making case-management decisions and to reference this information in the activity logs.

- In response to two recommendations to remind workers to use available interpreter services and to access the Diversity Website, Salt Lake Valley Region responded that it had been proactively referring workers to the Diversity Website, that administration had sent a region-wide email emphasizing the importance of and process for using correct interpretation services, and that the region would formally support broader use of the Diversity Website. Workers in the region were provided with an Interpreter Contract resource list and lists of non-certified and certified DCFS staff that could assist with the interpretation of at least twelve languages.

DCFS State Office administrators noted that current Practice Guidelines did not provide clear direction on several issues raised by the Child Fatality Review Committee. They responded to recommendations as follows:

"In reviewing current Practice Guidelines DCFS found that there is no clear direction for caseworkers to update information at the conclusion of the case. The following will be added to Practice Guidelines for the October 2009 release:

1. Workers will update victims, allegations, addresses, and birthdates at case closure to ensure that the information is as accurate as possible. This process includes adding victims and allegations to the CANR as information is discovered during the course of the investigation.

2. As soon as a worker begins to work with a family, safety assessments must occur. Based on these ongoing assessments, any actions taken by the family that are not in harmony with "the plan" can be weighed against the safety assessments. In every case the worker needs to determine the threats of harm to the children, the protective capacity of the caregiver and the child's vulnerabilities. If the determination, based on the assessment of these factors, is that the children will only be "safe" if the parents connect with domestic violence services, the worker would need to make every effort to locate the family and compel them to accept and involve themselves in services. If the assessment is that services would be helpful but not necessary and that the children are generally "safe", the worker can close the case with a finding on the allegation(s) without having located the family. It is imperative that caseworkers thoroughly document the process they use and

the rationale behind their determination to attempt to locate a family or to close the case without having located the family.

a. DCFS will add language to CPS Practice Guidelines that requires caseworkers to assess safety and document threats of harm, child vulnerabilities, and protective capacities of the caregiver as they move through the case.

b. DCFS will add that if there is concern for the child's safety based on the assessments and if the family disappears, the worker must go through the protocol to locate the family.

c. When caseworkers are attempting to locate a child/family, they must be careful to protect the rights of the family to confidentiality and may reveal only that they are with Child Protective Services and are trying to locate a child. They may not reveal the nature of the allegations or discuss the interactions they have had with the child/family.

3. DCFS will make additions to Unable to Locate Practice Guidelines to include adding any allegations from a case closed with a finding of "Unable to Locate" to any subsequent case allegations. This information will also be added to Practice Guidelines regarding reviewing prior cases records.

4. DCFS will also look at the Practice Guidelines for handling Domestic Violence cases. If necessary, language will be added indicating that caseworkers will offer services to the non-offending parent apart from the alleged perpetrator.

5. The DCFS State Office is also emphasizing the role of supervisors in insisting on casework that is at least to the level of minimally acceptable practice and in educating caseworkers on activities that will bring their work to the level of best practice.

Fatality Review Committee recommendations have contributed to DCFS's development of the following trainings and improvements:

- An intra-web training site is being developed and was to be completed and online by March 2009. The site will include already-developed information on safe sleeping practices for infants and additional information pertaining to child vulnerability and issues that might impact a child's safety.

- Training on Safety Model concepts began in the fall of 2007, was completed throughout the State, and is now incorporated into New Employee Training. The model emphasizes the assessment of a child's safety as being central to Intake and CPS workers' decision making and vital in visiting and reunification decisions made by on-going workers. The training provides language for caseworkers to use in talking about safety, additional information on assessing for safety, and an emphasis on making continual assessments for safety throughout the life of a case.

- Handbooks have been developed that cover tasks related to Transition to Adult Living, Intake, Purposeful Visiting, and Child Protective Services. The books are currently being reviewed by different regions in terms of feedback concerning which sections will be helpful for training purposes.

- Two separate Child Interviewing trainings have been developed. The first training, "Child Interviewing for CPS Staff Including the Proper Use of Audio Recordings", has been delivered across the state. DCFS has also developed a contract with the University of Utah for Motivational Interviewing, which is offered to Program Area staff in CPS, as well as In-home and Foster Care. This training has been completed in Salt Lake Valley and Northern Regions and began in Western Region in January 2009.

- The Practice Model "Assessing" module was revised to include specific information on maltreatment and safety and how workers will assess these factors. With the conclusion of the Federal lawsuit DCFS is beginning revisions of all Practice Model modules, as well as reviewing all core trainings for updates.

- Secondary Traumatic Stress training was developed to assist caseworkers in addressing the trauma that they experience in their work with victims of abuse and neglect. It was trained in Salt Lake Valley Region, and all regions provided this training beginning in 2009. A Peer Support Training has also been developed that will allow for debriefing of casework staff when they are experiencing traumatic events.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY PLACEMENTS

SYSTEMIC STRENGTHS

DSPD Support Coordinators act as advocates for individuals who are receiving services through the Division and through its contract providers. They verify and provide appropriate documentation necessary for ensuring an individual's eligibility for waivered services, provide crisis intervention when necessary, monitor the delivery and appropriateness of contracted services, review monthly provider reports, and assess an individual's well-being through in-person visits in the home or at day-support sites. The DSPD Fatality Review Committee recognized the excellent work of several Support Coordinators and recommended that they be commended for their outstanding work.

Staff from several contract providers were recognized by the Committee for their excellence in caring for individuals and for their exceptional efforts to provide comfort to individuals suffering from terminal medical conditions. Staff from Futures through Choices, Mosaic, Danville Services, and Key Residential were commended for their outstanding work.

- The Futures through Choices RN conducted a nursing assessment by tracking and graphing an individual's bouts of diarrhea and chronic stomach pain. She recommended that the individual receive a physical examination, which revealed no problems. However, several months later the man was diagnosed with a perforated intestine and underwent emergency surgery. Following surgery, Futures through Choices staff spent many hours sitting with the individual and advocating for him with hospital nurses and doctors. The hospital RN had also worked for Futures through Choices and was skilled in interacting with DSPD clients.

- While receiving services under the Physical Disabilities Waiver, a woman was provided with an extensive array of services. However, due to her abrasive personality and mental health issues, home health care agencies refused to provide services, and she was unable to retain personal assistants. The DSPD RN invested a great deal of time in dealing with the woman and with her care providers in an attempt to coordinate services and to ensure that the woman was safe in her home environment. The RN acted as an intermediary with service-providing agencies and fielded complaints from the woman's employees.

- A woman who communicated through sign language received caring and conscientious care from Danville staff. As the woman's physical appearance was very important to her, Danville staff ensured that she had hair and nails professionally done on a regular basis. Staff learned to understand and to use the woman's sign language in order to communicate with her, and they encouraged her to participate in activities and to be more social.

- In an effort to stabilize a diabetic man's blood sugar levels, Mosaic staff ensured that the individual was taking his medications as prescribed, monitored his blood sugar levels, provided several healthy choices for meals and snacks, encouraged the man to walk on a daily basis, and tracked and documented the individual's exercise efforts. Staff also assisted the individual with his hygiene needs by verbally prompting him to bathe, shave, wash his hands, and clean under his fingernails. They assisted him by washing his hair, cutting his nails, and maintaining a clean and safe environment. While the individual was

hospitalized, Mosaic staff monitored his progress and expressed concerns about the care he was receiving.

- When a woman was diagnosed with a very rare B-cell of unknown type Lymphoma, Extended Living Services (ELS) were opened to allow her to remain in her home provided by Key Residential Services (KRS). KRS staff were skilled in communicating with the woman and were aware of her special care needs. The woman's parents expressed appreciation to KRS staff for the loving care they gave their daughter and stated that she had accomplished things while under KRS staffs' care that they could never have imagined possible.

The DSPD RN's continue to provide an excellent resource for Support Coordinators as they deal with the health and safety issues of individuals in service. Many of the individuals receiving services through DSPD and its contract providers are diagnosed with numerous medical and/or behavioral problems for which they receive treatment and prescription medication. Individuals who are immobile are subject to skin breakdown that can lead to serious, and even life-threatening, wounds. RN's visit with individuals in their homes, in hospitals, and in care centers to make assessments of their medical condition and to monitor their progress and the quality of care they are receiving. The RN's have knowledge of prescription medications, their uses, the signs of adverse drug interactions and possible side effects. They can monitor the effectiveness and/or appropriateness of these medications and alert medical personnel to potential medication-related problems. In some instances the RN's act as a liaison between medical professionals and providers, family, and DSPD, and they participate with hospital personnel in discharge planning. The Committee continues to recognize the excellent work of the DSPD RN's in all regions.

SYSTEMIC WEAKNESSES

In the majority of cases reviewed in FY 2009 the level of care for individuals appears to have been appropriate and to have been provided as contracted. Individuals were provided with multiple services, excellent medical, dental, and mental health care, and opportunities to participate in meaningful work and community and social activities. Provider staff worked with several individuals in planning and shopping for nutritious meals and in encouraging them to exercise in order to reach or maintain a healthy weight. With the help of respite and supported living services twenty-two individuals (44%) were able to remain in their homes and to be cared for by family members.

During FY 2009, the DSPD Fatality Review Committee noted some isolated concerns related to the delivery of provider services and to other systemic issues.

Client Visitation

In four cases (8%) the Committee noted that Support Coordinators had not made monthly face-to-face visits with their clients or had not met Medicaid requirements for face-to-face visits with individuals living at home. The Committee recommended that these workers be reminded/re-trained on these requirements.

Documentation

Although documentation problems were not pervasive in the cases reviewed this fiscal year, the Committee made recommendations for improvement in several areas. In two cases (4%) it was suggested that workers enter a brief summary of monthly provider reports rather than copying and pasting entire reports into the activity logs. In one case file (2%) the Social History forms for the past several years were blank or incomplete. In one case (2%) the information contained in an Incident Report from Chrysalis contained an inadequate summary and was missing important

information such as the nature of the incident, names of individuals involved, the length of the illness before the individual was hospitalized, and the location where the incident occurred.

In each of these cases the Committee made recommendations for the individuals/providers to receive additional training on appropriate methods of recording information in activity logs and on the necessity of having current documents in the case file. The Committee recommended that contract provider staff be trained on writing useful and informative incident reports and requested that the provider submit verification that the training had been conducted.

DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action they initiated to comply with recommendations, and for their formal written responses to the Fatality Review Committee. Following are examples of division responses:

- In response to the Committee's recommendation that supervisors and support coordinators receive a refresher training on when and how to make Adult Protective Services (APS) reports, the APS Lead Worker in the St. George office provided this training to the DSPD supervisor and his staff. The Director of Adult Protective Services also reported that their trainer was collaborating with the DSPD trainer to coordinate and provide this training.

- In a case where the Support Coordinator had not been making monthly face-to-face visits with his clients, the supervisor reviewed best practice related to this subject and is meeting with the worker on a weekly basis for a report on his client contact. The supervisor is also conducting a random check of the worker's files, checking USTEPS, and calling parents and others to ensure that the visits are being done.

- A Region Director requested that a supervisor retrain his Support Coordinator on the importance of accurate and thorough file documentation including assessments, social history, case logs, and other required items. The supervisor was also asked to complete a random audit each month on two to three cases to ensure that the Support Coordinator's documentation continued to be current and accurate.

.

UTAH STATE DEVELOPMENTAL CENTER

Utah State Developmental Center (USDC) reported the deaths of seven individuals who were residents of that facility**.** Each of the seven individuals died at American Fork Hospital, American Fork, Utah. Formal death reviews are pending for these individuals and will be held at USDC when officials have received all medical records and other pertinent information concerning the deaths.

Natural Causes is listed as the manner of death for six of the individuals, and Accident is listed as the manner of death for one individual. Three individuals died of aspiration pneumonia, one individual died of aspiration of emesis, one individual died of a recurrent bowel obstruction, one died of respiratory distress due to systemic inflammatory response, and one individual died of airway obstruction due to the aspiration of food.

DIVISION OF AGING AND ADULT SERVICES

During FY 2009, two reported fatalities from the Division of Aging and Adult Services met DHS fatality review criteria. One individual died in his home, and the other individual died at a hospice care center. The cause of death for one individual was certified as "Natural Disease", and the cause and manner of death are pending in the death of the second individual.

The two individuals were reported as victims of alleged abuse or neglect, and the reports were investigated by Adult Protective Services (APS). APS investigators conducted thorough investigations into reports of Caretaker Neglect, Financial Exploitation, and Emotional Abuse/Harm and made dispositions based on information gathered and assessments made.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

UTAH STATE HOSPITAL

During FY 2009, Utah State Hospital reported the deaths of three individuals who were receiving or who had received services from that facility within ninety days of their deaths and reported the death of one USH employee, a Registered Nurse, who died at USH while on duty. Two individuals were open for services through USH at the time of their deaths, and one individual had been released from USH to a respite care center two weeks prior to his death. Two individuals died at Utah Valley Regional Medical Center (UVRMC), Provo, Utah, and one individual died in a respite care center in Provo, Utah. The manner of death for each individual was "natural causes" with the causes of death being cancer, morbid obesity, septic shock due to small bowel necrosis, and seizure disorder.

- An individual, who was admitted to USH in September 2007, had a history of colon cancer with surgical intervention and had experienced recurrent small bowel obstructions since 2002. The individual also had insulin-dependent diabetes, which was complicated by GI difficulties and absorption disruption. USH made many referrals to specialists and provided excellent care for the individual's medical needs, and he was hospitalized multiple times for non-psychiatric treatment. However, in October 2008, the individual experienced decreased oxygen saturation, severe abdominal pain, and increased abdominal girth and received no relief through the medical interventions provided at USH. He was transferred to Utah Valley Regional Medical Center where he ultimately underwent two separate surgeries and was placed on life support. Members of the individual's family made the decision to discontinue life support.

- Another individual was admitted to USH in October 2006 and was being treated for schizoaffective mood disorder, alcohol dependence, cannabis abuse, and borderline intellectual functioning. His Axis II diagnosis was significant for seizure disorder, which had not been manifest for several years prior to his death. The individual suffered a seizure and was transferred and admitted to Utah Valley Regional Medical Center. It was noted that the individual had a history of hyponatremia, which is an electrolyte disturbance in which the sodium concentration in the plasma is lower than normal. Following the ER visit, the patient was placed on fluid restriction and was started on an anti-seizure regimen. Approximately one month after returning to USH the patient experienced two seizures and was transferred to UVRMC once again. The ER physician took an aggressive approach to treatment but failed to review medical information in the individual's Emergency Transfer Packet, which had been sent with him, stating that the individual had hyponatremia and a seizure disorder. Medical personnel administered four

liters of normal saline, and it was learned that the individual had been given intranasal Versed during transport. After several hours in the ER the individual's lab results indicated that his sodium level had dropped significantly. The patient was intubated after experiencing periods of apnea and was ultimately placed in ICU. Tests showed that the man had negative results on brain activity and breathing tests. His family made the decision to discontinue life support, and the individual died three days after having been admitted to the hospital. A member of USH administration and administrators and doctors of Utah Valley Regional Medical Center attended a review on the case.

Based on review findings, the fatality review committee recommended that USH develop a universal protocol for patients diagnosed with hyponatremia, and it was proposed that Continuing Medical Education (CME) be held on the subject of treatment of hyponatremia. In response to this recommendation medical staff reviewed the idea of developing an hyponatremia protocol. Because medical guidelines to treat hyponatremia are already in place, staff determined that it was not necessary to develop a USH policy but concluded that training would be sufficient. A CME on the treatment of hyponatremia was conducted for all staff in October 2008.

It was noted that when an individual experienced a seizure lasting longer than three minutes, USH staff should call '911' and Code Blue. In response to this discussion the Director of Nursing reviewed and revised Code Blue Policy. Training on the revised policy was conducted and monitored until November 22, 2008, with staff compliance at 90%.

In response to a situation in which the attending doctor could not locate morphine for a patient's abdominal pain, it was arranged with the pharmacy doctor that in the future morphine would be available in the after-hours cabinet.

The Utah State Hospital Clinical Director and the Clinical Risk Manager conducted an on-site Risk Management Fatality Review for each case. Due to the reclassification of DHS Fatality Review reports as Private which creates the possibility of HIPPA violations, USH no longer provides DHS with reports of its reviews.

DIVISION OF JUVENILE JUSTICE SERVICES

The Committee received notification of the deaths of seven Division of Juvenile Justice Services (DJJS) clients. Four of the decedents had received service through both DJJS and DCFS. The manner of death is certified as "Suicide" in four cases with two youth dying from self-inflicted gunshot wounds and two youth dying from asphyxia due to hanging. One youth died of multiple gunshot wounds in a "Homicide" death, and two youth died of drug toxicity with one's manner of death certified as "Accident" and the other manner of death certified as "Undetermined" One youth was in DJJS custody at the time of his death but was on parole and was on a trial home placement. The remaining six youth had been terminated from DJJS custody at the time of their deaths. Following are summaries of circumstances surrounding the deaths of two DJJS clients:

- A youth with a history significant for suicidal ideation, self-mutilation (cutting), auditory hallucinations, and sexual victimization was found unresponsive in his room at a DJJS secure placement facility. After removing the bed sheet wrapped around the youth's neck JJS staff administered CPR. The youth was transported to a local hospital and was later released to a nursing home where he remained until his death two months later. The cause of death is certified as Hypoxic Encephatopathy and Complications due to Hanging. The court terminated DJJS custody approximately one month before the youth's death.

- Another youth had been in DCFS custody and substance abuse treatment programs for more than three years, during which time he went AWOL from his placements multiple times. He continued to use drugs, did not comply with services or with court orders to make restitution, and was reportedly taking probation lightly by continuing to go AWOL. In October 2008 the youth was ordered into DJJS custody and into a community-based placement. The youth did well in his treatment program, volunteered to participate in restitution projects, made good progress in working off his Community Service hours, and eventually earned home visits with his mother. He completed his court obligations and was granted a trial home placement. In January 2009 the youth was successfully terminated from DJJS custody and guardianship and indicated that he wanted to go back to school to earn a high school diploma. A week after being terminated from JJS custody the youth was kidnapped by four individuals, was robbed, and was shot multiple times. The manner of death is certified as "Homicide". The four youth were arrested on aggravated murder, aggravated kidnapping, and aggravated robbery charges.

SYSTEMIC STRENGTHS
In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive assessments and services that included individual and group therapies, medication management, life skills training, substance abuse counseling and treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

SYSTEMIC WEAKNESSES
The DJJS Fatality Review Committee did not identify any practice concerns or systemic weaknesses in the DJJS cases reviewed.

OFFICE OF THE PUBLIC GUARDIAN

During FY 2009, the Office of the Public Guardian (OPG) reported the deaths of eight individuals for whom they had provided guardianship services. One client was also receiving services from the Utah State Developmental Center through the Division of Services for People with Disabilities, and one individual had received Adult Protective Services through the Division of Aging and Adult Services. Two individuals were hospitalized at the time of their deaths, and six individuals were in rehabilitation/care facilities. All deaths were certified as "Natural Causes" with the causes of death being certified as cancer, respiratory failure, stroke, cardiopulmonary arrest, decubitle gangrene, and three cases of pneumonia.

OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients' service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT
SUMMARY
FY 2009

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Cases Reviewed	Committee Review Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**129**	**106**	**121**	**27**	**8**	**71**	**58**
DAAS ***(Division of Aging and Adult Services)***	2	2	2	0	0	1	1
DCFS ***(Division of Child and Family Services)***	49	24	49	26	0	29	20
DCFS/DSPD *(Division of Child and Family Services/Division of Services for People with Disabilities)*	3	3	2	1	1	1	2
DJJS *(Division of Juvenile Justice Services)*	3	1	3	0	0	3	0
DJJS/DCFS *(Division of Juvenile Justice Services/ Division of Child and Family Services)*	4	1	4	0	0	4	0
DMH - USH ***(Division of Mental Health - Utah State Hospital)***	4	2	4	0	0	3	1
DSPD – COMMUNITIY PLACEMENT ***(Division of Services for People with Disabilities)***	50	49	49	0	1	24	26
DSPD - USDC (Division of Services for People with Disabilities *- Utah State Developmental Center)*	6	6	0	0	6	4	2
USDC/OPG *(Utah State Developmental Center/Office of the Public Guardian)*	1	1	1	0	0	0	1
OPG *(Office of the Public Guardian)*	7	7	7	0	0	2	5

CHART I

FIVE-YEAR COMPARISON
FY 2005 – FY 2009

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
DHS Reported Deaths	106	100	133	171	129
DAAS	1	0	3	3	2
DCFS	40	31	49	59	49
DCFS/DSPD	1	1	1	1	3
DJJS	7	2	3	2	3
DJJS/DCFS	0	1	1	2	4
DMH - USH	2	2	4	10	4
DSPD	43	57	57	75	49
DSPD/OPG	0	0	3	2	1
DSPD – USDC	5	3	3	4	7
OPG	7	3	9	13	7
Cases Open at Time of Death	76	79	101	124	106
Cases Reviewed	101	97	124	139	121
Abuse & Neglect Deaths	5	6	11	22	4
Accidental Deaths	13	8	15	10	12
Homicides	4	3	5	14	5
Motor Vehicle Accidents	8	3	5	9	1
Suicides	9	1	4	5	7

CHART II

AGE AT TIME OF DEATH
FY 2009

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/ DSPD	DJJS	DJJS/ DCFS	DSPD	OPG	USDC	USH
< 1	31		31							
1 – 3	7		6				1			
4- 6	1						1			
7- 10	6		5				1			
11 - 14	6		3	1			2			
15 - 18	11		4	1	2	4				
19 - 30	13			1	1		10			1
31 – 50	16						14		1	1
51- 65	23						16	2	3	2
66 – 80	11	1					5	2	3	
81 - 90	4	1						3		
TOTALS	129	2	49	3	3	4	50	7	7	4

CHART III

MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2009

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	OPG	USDC	USH
Accident	12		10	1			1	
Homicide	6	1	4	1				
Natural Causes	94	1	28		48	7	6	4
Pending	1				1			
Suicide	7		3	4				
Undetermined	9		7	1	1			
TOTALS	129	2	52	7	50	7	7	4

CHART IV

ACCIDENTAL DEATHS
FY 2009

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia – Airway Obstruction	1	Male	36	USDC
Asphyxia - Hanging	2	Male	4 months	DCFS
		Male	10 months	DCFS
Asphyxia – Positional	2	Female	2 months	DCFS
		Male	2 months	DCFS
Drowning	2	Female	15 months	DCFS
		Male	3	DCFS
Drug Intoxication	2	Male	18	DJJS/DCFS
		Male	16	DCFS
Hypothermia	1	Male	14	DCFS
Motor Vehicle Accident	1	Male	13	DCFS
Motor Vehicle/Bicycle	1	Male	10	DCFS
TOTAL	12			

CHART V
HOMICIDE DEATHS
FY 2009

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Caretaker Neglect	1	Female	90	DAAS
Inflicted Injuries	4	Male	4 months	DCFS
		Male	6 months	DCFS
		Female	2	DCFS
		Female	2	DCFS
Gunshot Wounds	1	Male	18	DJJS/DCFS
TOTAL	6			

CHART VI
SUICIDE DEATHS
FY 2009

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	2	Male	18	DJJS
		Male	17	DJJS/DCFS
Gunshot Wound	4	Female	16	DCFS
		Female	16	DCFS
		Male	18	DJJS/DCFS
		Male	20	DJJS
Unknown	1	Male	12	DCFS
TOTAL	7			

CHART VII
ABUSE/NEGLECT DEATHS
FY 2009

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Decubitle Decubitle Gangrene	1	Female	90	DAAS
Drowning	2	Female	15 months	DCFS
		Male	3	DCFS
Inflicted Injuries	4	Male	4 months	DCFS
		Male	6 months	DCFS
		Female	2	DCFS
		Female	2	DCFS
TOTAL	7			

CHART VIII
FATALITIES BY REGION AND OFFICE
FY 2009

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL	OFFICE	TOTAL
Central	1		
		Holladay	1
Western	1		
		Provo	1
TOTAL	2		2

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL	OFFICE	TOTAL
Eastern	2		
		Castle Dale	1
		Vernal	1
Northern	9		
		Bountiful	2
		Clearfield	2
		Ogden East	5
Salt Lake Valley	26		
		Administration	3
		Jackson	2
		Magna	1
		Metro	2
		Mid Towne	4
		Oquirrh Neighborhood	6
		Salt Lake West	3
		South Towne	3
		TAL	1
		Tooele	1
Southwest	6		
		Cedar City	3
		Manti	1
		St. George	2
Western	7		
		Heber City	3
		Orem	1
		Provo	1
		Spanish Fork	2
TOTAL	50		50

CHART VIII (Continued)
FATALITIES BY REGION AND OFFICE

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL	OFFICE	TOTAL
Region I	4		
		Bountiful	1
		Ogden	1
		Ogden/Logan	1
		Logan	1
Region II	3		
		Salt Lake City	3
TOTAL	7		7

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY BASED and
UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL	OFFICE	TOTAL
Central	22		
		Administration	6
		Evolve 2, LLC	1
		Heber City	1
		Holladay	14
Northern	9		
		Clearfield	5
		Logan	1
		Ogden	2
		State Street – SLC	1
Southern	21		
		American Fork	4
		Nephi	2
		Provo	5
		Richfield	2
		Spanish Fork	3
		St. George	5
USDC	7		
		American Fork	7
TOTAL	59		59

CHART VIII (Continued)
FATALITIES BY REGION AND OFFICE

DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH
UTAH STATE HOSPITAL

REGION	TOTAL	OFFICE	TOTAL
USH	4		
		Provo	4
TOTAL	4		4

OFFICE OF THE PUBLIC GUARDIAN

REGION	TOTAL	OFFICE	TOTAL
Central	7		
		Administration	7
TOTAL	7		7